USAID DU PEUPLE AMERICAIN | SDSH SANTÉ POUR LE DÉVELOPPEMENT ET LA STABILITÉ D'HAÏTI

Santé pour le Développement et la Stabilité d'Haïti
Pwojè Djanm

Semi-Annual Report — October 2011 to May 2012
Contract No. GHS-I-00-07-00006-00
Order No. GHS-I-01-07-00006-00

June 2012

This publication was produced by Management Sciences for Health for review by the United States Agency for International Development. The views expressed herein do not necessarily reflect the views of USAID or those of the United States Government.

Semi-Annual Progress Report

October 1, 2011 to May 31, 2012

Santé pour le Développement et la Stabilité d'Haïti — Pwojè Djanm
Contract No: GHS-I-00-07-00006-00
Order No: GHS-I-01-07-00006-00

Management Sciences for Health
784 Memorial Drive
Cambridge, MA 02139
Telephone: 617.250.9500
www.msh.org

Management Sciences for Health – Haiti
27, Frères 31, route de Frères, Delmas 105
En face rue La Pépinière
Pétion-Ville, Haiti
Téléphone: 509.2510.9901 @ 9902

Website: www.msh.org

mshhaiti@mshhaiti.org

Santé pour le Développement et la Stabilité d'Haïti / Pwojè Djanm: Semi -Annual Report, July 10th, 2012. Cambridge MA: Santé pour le *Développement et la Stabilité d'Haïti—Pwojè Djanm*; Management Sciences for Health, 2012.

This publication was produced by Management Sciences for Health for review by the United States Agency for International Development (USAID). The authors' views expressed in this publication do not necessarily reflect the views of USAID or the United States Government (USG).

Contents

Acronyms

AIDS	acquired immunodeficiency syndrome
ART	antiretroviral therapy
ARV	antiretroviral (medicine)
BCC	behavior change communication
CA	Contracts and Administration
CBO	community-based organization
CBP	*Centre de Bienfaisance de Pignon*
CDS	*Centre pour le Développement de la Santé*
CM	community mobilization
CONASIS	*Comité national du système d'information sanitaire*
CS	*centre de santé* (health center)
CYP	couple years of protection
DRI	Development Relief International
DTP3	diphtheria, tetanus, pertussis (vaccine)
FBO	faith-based organization
FONDEFH	*Fondation pour le Développement de la Famille Haïtienne*
FP	family planning
FY	fiscal year
GUC	grants under contract
HIS	health information system
HIV	human immunodeficiency virus
ICC	International Child Care
IDP	internally displaced people
IV	Intravenous
LMS	Leadership, Management and Sustainability (Program)
MEBSH	*Mission Baptiste du Sud d'Haïti*
MIS	management information system
MSH	Management Sciences for Health
MSPP	*Ministère de la Santé Publique et de la Population* (Ministry of Public Health and Population)
NGO	nongovernmental organization
OBCG	*Oeuvre de Bienfaisance de Carrefour et de Gressier*
OBDC	*Oeuvre de Bienfaisance et de Développement Communautaire*
OFDA	Office of US Foreign Disaster Assistance [USAID]
ORS	oral rehydration salts
PBF	performance-based financing
PCR	polymerase chain reaction (test)

PMP	Performance Monitoring Plan
PMS	Paquet Minimum de Sante
PMTCT	prevention of mother-to-child transmission
PNLT	*Programme National de Lutte contre la Tuberculose*
RH	reproductive health
SADA	Service and Development Agency
SCMS	Supply Chain Management System (PEPFAR USAID-administered project)
SDSH	*Santé pour le Développement et la Stabilité d'Haïti*
STI	sexually transmitted infection
STTA	short-term technical assistance
TB	tuberculosis
TBA	traditional birth attendant
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
USG	US Government
VCT	voluntary counseling and testing (for HIV)
WHO	World Health Organization
WINNER	The Watershed Initiative for National Natural Environmental Resources (Project)
ZC	*zone ciblé*

EXECUTIVE SUMMARY

Introduction

The *Santé pour le Développement et la Stabilité d'Haïti* (SDSH) Project is USAID Haiti's flagship health sector activity. It was awarded to Management Sciences for Health (MSH) in August 2007 for an initial period of three years. Two years later, the project received a one-year cost extension that increased the life-of-project funding from $42.5 million to $81.4 million and changed the completion date to September 30, 2012. (Currency is in U.S. dollars throughout this report.)

SDSH builds on the successes and lessons learned from earlier MSH projects, namely Haiti Health Systems 2004 (HS2004) and Health Systems 2007 (HS2007). Similar to its predecessor projects, SDSH was designed to increase access to and use of a package of integrated basic health services that covers maternal and child health, nutrition, family planning (FP), HIV/AIDS, and tuberculosis (TB). To achieve its objective, SDSH supports public, private, and nonprofit sector health care delivery and reinforces the capacity of Haiti's *Ministère de la Santé Publique et de la Population* [Ministry of Public Health and Population (MSPP)] to carry out its executive management and oversight functions at the central and departmental levels. SDSH is differentiated from earlier projects by its heightened focus on public sector institutional strengthening and capacity-building using a model that has proven successful with private sector partners.

Project service delivery activities are implemented through performance-based financing (PBF) subcontracts with 28 local nongovernmental organizations (NGOs) that operate 79 health facilities and through 81 MSPP public sector sites in 33 geographical areas known as *zones ciblées* (ZCs). The project's primary beneficiaries are (1) children and youth under 25 years of age, (2) women, and (3) special concerns groups including persons living with HIV, AIDS, and TB. SDSH currently covers 43 percent of the Haitian population, or 4,347,198 inhabitants.

As a testimony to the confidence placed by external benefactors in SDSH's ability to deliver results, the project not only met its contractual matching funds requirement in less than two years but also continues to leverage funds and substantial in-kind support from a wide range of contributors.

Progress Highlights

In spite of staffing and environmental challenges, SDSH delivered results, meeting or exceeding most of its targets in each program element. The program **supported the MSPP** through ministry-led initiatives for nationwide strategic planning, saw the appointment of a new minister and adjusted project milestones according to her priorities for the ministry, and continued implementation and promotion of performance-based financing for public- and private-sector partners. SDSH also expects to provide key technical support to the MSPP's establishment of a contracting unit. The Grants Under Contract effort has helped 20 community-based organizations (CBOs) mobilize, manage their initial grant, and implement their programs; having proven the ability of CBOs to absorb funding and deliver results, SDSH looks forward to providing additional funding for the establishment of local health task forces during the final months of the project.

To date, SDSH has greatly expanded **HIV services** to additional sites and additional people. Increased numbers of trained providers and service sites that offer VCT have helped more than 81,000 men and women, and another 43,219 pregnant women learn their HIV status. Nearly 700 HIV-positive pregnant women received PMTCT and 300 HIV-exposed newborns were tested using PCR-DNA in efforts to strengthen pediatric HIV services. Provider training and site-level service expansion made it possible for

network facilities to provide palliative care to nearly 20,000 PLHIV to date this year, to initiate 649 HIV-positive patients on ART, for a total of more than 5,000 patients who still receive treatment from SDSH-network facilities.

To serve patients infected with **tuberculosis (TB)**—including those also infected with HIV—SDSH-supported facilities worked to integrate HIV and TB services at 25 sites, and trained nearly three times as many providers as planned to screen for HIV and TB (29 providers trained to date, for an annual target of 10 providers). The percentage of TB patients screened for HIV has increased accordingly to 67% (surpassing a target of 30%).

Services for **maternal and child health** have made important in-roads in PY5. More pregnant women are receiving prenatal care during their first trimester, developing birth plans, and delivering their baby with a trained health worker present. While complete vaccination and DPT3 rates were below targets, child nutrition programs under SDSH are thriving and the numbers of under-fives who received vitamin A, and of mothers and caretakers trained to prevent and manage diarrhea surpassed project targets. SDSH also helped develop nine posters and 15 technical guidelines sheets to help improve maternal health services.

Emphasizing modern and long-term methods, SDSH-supported facilities met or exceeded most of its targets for **family planning and reproductive health.** The program trained more people than anticipated (75 people trained in FP and 35 staff trained in long-term methods, for targets of 50 and 35, respectively) and expanded the number of sites offering services, including long-term and permanent methods. As services continue to improve, uptake should as well. Very promising is the high percentage of Depo-Provera users who received their next injection on schedule (93%, for an annual target of 90%), indicating a commitment to family planning and reliable services.

Challenges and the Way Forward

In spite of ongoing challenges, SDSH has reached or exceeded the majority of its targets and continues to deliver essential care to almost half of Haiti's population. The PY5 focus on improving service quality will continue through the end of SDSH and into the one-year Bridge mechanism anticipated to begin this summer. An SDMA assessment revealed that sites still lack many resources to deliver high-quality care; efforts to address this will also continue from SDSH to the Bridge mechanism. A full transition of project capacities to MSPP central and departmental units will be challenging but it will be built upon a strong foundation of SDSH technical support and meaningful partnerships with public- and private-sector stakeholders in Haiti's health system.

Box 1. Success Highlights

For **HIV/AIDS**, SDSH met or exceeded 14 of its targets, including:

- People trained in VCT, and sites offering VCT services according to norms
- People, including pregnant women, getting tested for HIV and receiving their results
- People trained in laboratory services, and laboratory tests done by SDSH-supported labs
- Sites offering ARV
- People newly started, and people ever-started on ARVs
- Providers trained in PMTCT, and sites offering PMTCT according to international norms
- HIV-positive pregnant women on antiretroviral (ARV) prophylaxis
- Providers trained in palliative care, including for HIV and TB coinfection
- Sites offering complete package of palliative care to PLHIV
- HIV-positive people receiving palliative care, including those co-infected with TB and HIV

SDSH also exceeded the target for the percentage of **tuberculosis** patients tested for HIV and receiving their test results, the number of people trained in DOTS, and the number of providers trained for HIV and TB testing.

Results for **maternal health** activities were positive, with the project meeting or exceeding half of its targets:

- Percentage of pregnant women having their first prenatal visits during their first trimester
- Number of births attended by a trained health worker (not including traditional birth attendants)
- Number of postnatal home visits within 72 hours of delivery
- Percentage of new mothers receiving a postnatal consultation within 42 days
- Percentage of pregnant women with a birth plan

In the area of **child health**, SDSH met or exceeded targets for eight of its 12 indicators, including:

- Number of children younger than five years receiving vitamin A
- Number of infant pneumonia cases treated with antibiotics
- Number of children reached by nutrition programs
- Number of mothers and caretakers trained in diarrhea prevention and management
- Percentage of weighings for children younger than five years that show evidence or high risk of severe malnutrition, and that indicate a low or very low weight-for-age ratio.

The project met or surpassed eight of its 12 **family planning/reproductive health** targets:

- Number of sites offering FP counseling and services (long-term and permanent methods)
- Number of people trained in FP/RH, and number of staff trained in long-term FP methods
- Number of sites with strengthened MIS
- Percentage of Depo-Provera users who get their next injection on schedule

SDSH met or exceeded five of its eight targets for **public sector systems strengthening** activities, including:

- ZCs funded with PBF
- ZCs benefiting from the basic package of services supported by SDSH
- Number of health departments with a donor coordination mechanism, and implementing a service delivery supervision plan

I. SDSH Support to the Public Sector

IA. Strengthening MSPP Executive Functions

In consensus with the MSPP and taking into account national priorities, the project supports four main areas: (1) strategic planning and decentralization, (2) PBF, (3) governance and financial management, and (4) health information systems (HIS). In these domains, the project interventions were carried out at the central as well as departmental levels.

Strategic Planning and Decentralization

As part of strengthening strategic planning, SDSH staff participated in the MSPP-led initiative to organize extensive consultation meetings in December 2011 and January 2012. Meetings involved all stakeholders from the departments to the central level, and aimed to develop the national health policy and the national health sector strategic plan. Through the *Assises departementales* (Departmental stakeholders meetings) and *les Etats generaux de la sante* (Joint health sector review) representatives included heads of health facilities, representatives from the ministries of education and finances, civil society organizations, and religious leaders. These consultations were organized around five major themes: governance, decentralization, health financing and social protection, human resources management, and organization of service delivery and care. Project staff were involved both at central and decentralized consultations. They provided technical assistance to review the reporting framework template and harmonize the way information from the consultation meetings was documented in all departments. During the departmental consultations, SDSH staff contributed also by providing secretariat support and providing guidance to the health financing, governance, and organization of service delivery and care technical working groups during the consultation meetings in the Nippes, Central Plateau, North, and South East departments. Since the process was fully owned by MSPP, the role of consolidating all contributions from the national consultations belonged to MOH planning and monitoring Unit and its organizing committee composed of individual consultants and MSPP staff. At the time of writing, the final consultation reports had not yet been released.

Per USAID request, SDSH provided support to MSPP decentralization through efforts to develop referral networks. During the first and second quarter, the project carried out an assessment of the referral network from Cabaret to Montrouis and developed a business plan with costs necessary to turn Bercy Health Center into a functional site with a few beds and a focus on Maternal and child health services, and the possibility for trauma stabilization. SDSH shared regular reports and supporting documents with the USAID health team.

The project also started an assessment of three other referral networks around the current geographic space of the Unite Communale de Sante (UCS) of Matheux, Saint Michel de l'Attalay, and Ouanaminthe; the work is in progress for the last two. The assessment includes identification and mapping of all sites in the potential referral network, recoding of GPS coordinates, categorization of health facilities based on the services provided per the norms of the Minimum Package of Services (PMS), and a description of what the facility needs to perform at its expected level. During the same period and at USAID's request,

SDSH developed a framework of what is required to establish a referral network; the framework was shared with the USAID health team for future use.

There is need to mention that the concept or definition of a referral network is still under discussion, MSPP recognizes the need for mini-networks different from UCS to improve health service delivery; the latest development is the *Unite d'Arrondissement de Sante* (UAS) which is pending approval by parliament. Developing referral networks is a huge endeavor. To establish a sustainable health system, referral network design should occur within a clear health decentralization framework and policy reform that clarifies who pays for upgrades to health facilities or for services rendered (particularly to referred patients). SDSH did not have adequate staff to carry out these new activities with the intensity that they required, and was not able to accelerate this priority area for USAID.

Table 1. Strengthening MSPP Executive Functions Indicators

Met– 2	Number of health departments with donor coordination mechanism (6)
	Number of departments implementing supervision plan for service delivery (80% of target)
Exceeded- 3 	Number of ZCs funded with PBF (33)
	Number of ZCs benefitting from basic package of services supported by SDSH (33)
Under – 3	Number of departments with new financial and accounting management system set up and in use (7 for a target of 10)
	Percentage of departments implementing approved operational plan (-- %)
	Number of communes with ZCs where info system for services is set up and in use (--)
	Number of departments supported to operationalize the national HIS (0, for annual target of 6)

Performance-Based Financing

The project has managed 28 NGOs performance-based subcontracts and 33 performance-based public-sector MOUs since October 2011. The process to review partners' proposed work plans for October 2011 to June 2012 started late this year; local subcontracts and MOUs for zones ciblees were not signed until the end of October.

In February 2012, the project conducted the **Data Quality Assessment Survey for the period of October 2010 to September 2011.** The process was initiated in November 2011 when the SDSH Contract Office issued a request for proposals for the validation of data received from both public and private SDSH network institutions in order to determine each institution's percentage of performance and to make payments of award fees. Five consulting firms and consultants submitted their proposals; one firm (CERA) and one consultant (Josué Michaud) met the requirements and were selected.

If an institution's performance under PBF is measured by the percentage of award fee earned, a number of SDSH network institutions were did not perform well during the period October 2010 to September 2011. Among the 43 network institutions, three NGOs and one ZC obtained 100% of the award fee (or 6% of the approved budget amount): Clinique Dugué, Lucélia Bontemps, AEADMA, and the ZC Baie de Henne. Five partners obtained a performance score of 83% (equivalent to 5% of the approved budget amount): BERACA, CDS, FONDEFH, HHF, ZC Vallières, and ZC Sainte Suzanne.

The worst performing institutions of the SDSH Network for the period are: Hopital Sainte Croix, MEDISHARE, Centre de Santé Sacré Coeur de Thiotte, and Clinique La Fanmy. The heads of these institutions were requested to propose remedial actions before considering them for continued support; we do hope to see change for the final PY5 results.

The results of the *Département Sanitaire du Nord'Est* (DSNE) are among the most interesting. It is not clear if the results are sufficient to declare DSNE as the most effective department of the network for the period, however, the award fees obtained by Zones Ciblées ranged from 2% to 5% (see detailed results in Annex A):

- ZC Perches 2%
- ZC Mombin Crochu 3%
- ZC Carice 4%
- ZC Vallières 5%
- ZC Sainte Suzanne 5%

Work at central level to establish a PBF desk at MSPP was abandoned in March 2012 due to the potential conflicting nature with the processes to establish a Contracting Unit at MSPP with a broader goal of sector budget support. However, when invited, SDSH continues to participate in the national working groups to develop a national model for PBF, and continues to improve the SDSH performance-based contracting model for better quality of health services in the departmental health facilities.

The planned intervention with PRISMA project in Artibonite was also abandoned; PRISMA project leadership dropped the idea of using PBF mechanisms to improve MCH services in Artibonite because their donor (the CIDA Canada) is not familiar with the management of performance based contracts with local organizations and was not ready to take up the risks and engage alongside SDSH.

Financial Management Systems

Several activities planned to support financial management systems did not take place due to competing priorities. The departure of Uder Antoine, DCOP in charge of Finance and Administration and Systems Strengthening, in November 2011 somewhat delayed implementation in this area, and MSPP priorities were not clear during the period under consideration. Nevertheless, SDSH staffs were very busy during this period determining the standard costs of the PMS, the costing of Bercy business plan, and contributing to the costing of SDSH project activities carried out by Abt Associates, a USAID contractor hired to do the latter. The project presented preliminary findings from the PMS costing study to both the USG team and to the GOH. MSPP was very interested in knowing the per capita costs of the PMS for budget allocation purposes. Due to the wide variation of data—especially linked to the lack of adherence to norms for example the population in a health facility catchment's area—the study needs to be refined by rephrasing the working hypothesis, enlarging the sample size, stratification to ensure results could be generalized, and selecting an adapted methodology for the analysis and interpretation of results to respond to policy questions. MSPP established a task force led by UPE to review the study and improve the interpretation of results; meanwhile a number of competing priorities prevented UPE from convening the task force. SDSH hopes this activity will resume soon and plans to give the data set

to MSPP and train additional staff to use the CORE Plus tool to improve ownership and capacity with regard to costing health services. In May 2012, SDSH organized a training workshop on CORE Plus in the LMS conference room for 10 MSPP staff from the health financing desk to ensure they understand how to use the tool and would be able to carry out or at least participate in future costing studies using the same tool.

Health Information Systems

At the beginning of the year, the project's performance monitoring plan (PMP) was revised based on previous year results and submitted to USAID. The application used to track results of priority package of services (PSPI) was revised based on recorded changes in the structure of the SDSH network of partner institutions, particularly in their demographic targets (adjustment to population growth or catchment area). The updated dashboards were sent to Departmental Technical Advisors (CTDs), NGOs, and ZCs; the unit in charge of performance in collaboration with the contracts unit produced specific targets for each subcontractor that match project year five objectives; and all information was used to develop the contracts and payment schedules used to monitor PBF contracts. Monthly HIS reports from each site are a required deliverable of the subcontracts and contribute to the project's regular monthly progress report tables, thus keeping HIS up to date throughout the SDSH network. This deliverable has helped improve national HIS reporting through departmental directorates. Network data are reviewed, analyzed, and used by the SDSH technical team on a quarterly basis to identify strengths and weaknesses, and to adjust the program where necessary.

SDSH continued to provide technical assistance to all sites for data quality and reporting timeliness. At the beginning of the second quarter, a joint USAID and SDSH evaluation mission performed a data quality assessment to review the F indicators of the PMP. No major weaknesses that could affect the reliability of the statistics was observed. USAID is responsible for drafting the report; the final document has not yet been released at the time of this writing this report.

In a bid to map all SDSH network facilities, the project started collecting GPS coordinates for all the facilities during the second quarter; this will be finalized in the third quarter of project year five.

Human Capacity Development

The main strategy during project year five was the emphasis on improving the quality of services. It was necessary to review the service delivery organization model in order to consolidate the network's achievements and results obtained to date, and to build on lessons learned from previous years, guaranteeing the increases in service coverage and quality of care laid out in project objectives. SDSH conducted the service delivery assessments from November 2011 to January 2012 for selected health facilities using the Service Delivery and Management Assessment (SDMA) tool. The results obtained from this important activity highlighted the major strengths and weaknesses of the SDSH network and informed the content of a workshop on the organization and quality of service provision at both institutional and community levels. This workshop, held from 4 to 9 March 2012 at Club Indigo, targeted the CTD, various providers, and coordinators of targeted areas; some NGO leaders; and SDSH technical

staff. Participants discussed the SDMA results against the theoretical frameworks to improve the organization and quality of service delivery. This initial session was followed by a cascade of nine workshops led by the departmental directorates with the participation and support of all SDSH partners (including NGO partners). Each partner developed a concrete action plan for improvements in the participating institutions

In addition, the recommendations from the workshop will guide SDSH efforts to meet facility needs—such as supervision activities, capacity building of partner institutions, purchases of small equipment, minor renovations, and technical materials (*fiches techniques*)—to enable them to achieve their performance targets by the end of June 2012. Planned training activities were conducted directly or through a USG partner, and entered into the Trainet where training specific indicators are reported under each result area.

The SDSH Project supported the realization of key governance activities by the departmental directorates such as work planning sessions, supervision visits, training, and coordination meetings. During the months of February and March, all 10 directorates submitted work plans and budgets detailing the activities to be implemented. The requested funds were transferred by the end of March for activities running through June 2012.

Behavior Change Communication and Community Mobilization

The SDMA confirmed the non-availability of educational materials at service delivery points. The inventory of educational materials in stock (conducted in early March 2012) revealed the availability of only two pamphlets promoting family planning provided by USAID. The project decided to reproduce two brochures that cover most of the key messages on child health, maternal health, PMTCT, and family planning towards the end of the semester. This material will be distributed to all partner institutions and will serve to strengthen the educational work at Mothers' Clubs which were relaunched in six of the 10 departments: South East, North East, North West, South, Centre, and Grande Anse. One hundred and seventy-four providers working in targeted areas of these departments and NGO partners have been empowered to supervise health workers for the establishment of Mothers' Clubs during this semester.

In addition, the project has supported the dissemination of a series of 10 audio spots promoting maternal health services and PMTCT through 17 radio stations in nine of 10 health departments. Awareness material on hygiene promotion and hand washing were distributed to partner institutions by the project to commemorate the World Day of Hand Washing. This material was developed and produced by UNICEF to support the realization of educational activities on hand washing and sanitation, particularly in schools, by partner institutions.

SDSH continued to strengthen care and community support for people infected with and affected by HIV. This component of the HIV control program was relaunched at the beginning of the period under consideration. Interventions for palliative care and community assistance for orphans and vulnerable children (OVC) were conducted at the community level by 29 institutions including 27 partners who submitted regular progress reports using the Community-Based Information System (CBIS). Assistance to

OVC is provided by six sites for ARV treatment centers. SDSH provided close supervision via regular contact (phone, email, and visits) with partner institutions to monitor the implementation of agreed-upon action plans and of CBIS according to established procedures by the National Program to Fight HIV and AIDS. Reports available at the end of the semester reveal a network of 112 groups supporting 2,831 functional members, 8,392 PLHIV (approximately 45% of enrolled) who received care and support at the community level, and 3,710 OVC who benefited from SDSH assistance.

SDSH created linkages with the CHAMP project, several meetings were held between technical staff of both central and field levels from the two USAID-funded projects and they reached consensus on the modalities of an effective partnership to improve the continuum of care and support offered to PLHIV.

Other Support to Coordination and Technical Assistance

The main activities carried out under the coordination and technical support are summarized in the following list.

- Participation in the planning and organization of Intensive Child Health Activities (AISE-2012): attending meetings of the Interagency Consultative Committee (DPEV), and participating in the Committee of Social Mobilization and supervision activities of departmental directorates (training, micro planning, and coordination) from January to March 2012.
- Participation in activities with the Directorate of Family Health to update the IMCI training module.
- Coordination of training interventions on palliative community care with GHESKIO, INHSAC, and Project Measure (for tracking of community activities monitoring).
- Technical support to DPSPE: training departmental teams on Communication for Development (C4D) and developing the national hygiene promotion plan.
- Technical support to National program to fight HIV/AIDS (PNLS): preparation, facilitation, and documentation of meetings of the BCC/CM cluster.
- Participation in monthly meetings of the Technical Committee for Nutrition.
- Support to UPE: planning and preparation of the workshop on MSPP-SDSH partnership.
- Participation in meetings of the technical working group for the scaling up of the *Fanmi Kore* approach, a community intervention spearheaded by the office of the First Lady and the World Bank.

IB. Support for Decentralized Services

In the context of reinforcing community mobilization activities and implementing the local health task forces, SDSH continued technical support to the recipients of SDSH Grants under Contracts (GUC) for the promotion of health services and healthy behaviors. Technical support helped recipients to complete the implementation of planned GUC activities.

In February 2012, SDSH launched the second phase of the GUC program. Twelve new grants and 87 subgrants were awarded for a total of US$267,806.25. A workshop was organized under the theme "Consensus on the Implementation of Local Health Task Force," to review progress on the

implementation of the Communal Councils of Health. Representatives of 20 community-based organizations (eight of the first phase, 12 of the second phase) shared with newcomers experiences and lessons learned managing community mobilization under the GUC program. These CBO representatives have expressed satisfaction with the experience and they said that they particularly appreciated the opportunity to decide which interventions to pursue, but also the coaching they received from the SDSH staff.

Analysis of reports received has led to a better understanding of the challenges encountered in the field and a better appreciation of the efforts of partner organizations. SDSH is preparing a specific report on the challenges and lessons learned for the GUC mechanism.

On the second day of the workshop, new partner organizations received an orientation session on business planning and grant management. They were thus able, with the technical support from SDSH, to finalize the documentation to be submitted to USAID for approval of grants. The process was completed successfully, Mission approval was received in March, and grant agreements were signed and disbursed according to payment schedule as of April 2012.

The GUC partners did not receive sufficient funding to complete the establishment of local health task forces. The GUC is a new experience, thus SDSH allocated funding sufficient only for community activities as a way to monitor if the grassroots organizations could absorb the funding and deliver on plan. The experience has been successful; the project will complete the provision of funding to establish local health task forces in June if the funding is approved by USAID. The establishment of local health task forces in the interventions areas supported by SDSH will make it possible to create a partnership with the community to help improve the quality of health services provided and, consequently, increase their use.

By capitalizing on human resources available at community level, SDSH has an invaluable opportunity to supplement and extend, in a very efficient way, the sensitization and education activities carried out by the health service providers. Undeniably, members of the community, once empowered, will be able to more easily carry out their activities by taking into consideration the reality within their community and the availability of the participants.

II. SDSH Support for Service Delivery

IIA. HIV/AIDS

HIV-Voluntary Counseling and Testing

The objective for the semester was to provide voluntary counseling and testing (VCT) to 70,000 informed and consenting people of both sexes through 42 sites. This represented expansion to ten sites more than PY4's target of 32. These sites were selected from supported ZC and Watershed facilities; 67 providers were trained in counseling and testing and in the use of the finger prick method, enabling them to handle increased demand for services in their communities.

The project provided technical assistance to improve service organization and capacity strengthening for effective implementation of the full range of VCT services *(VCT éclaté)*. To date, 81,389 persons of both sexes (34% men and 66% women, not including pregnant women) and 43,219 pregnant women were tested and counseled and received their results.

Two factors in particular could explain this high level of performance: service integration and the extension of testing services. HIV testing has been integrated with other services offered at all SDSH-supported sites. This integration involved staff training, reorganization of services and patient flow, and availability of commodities and equipments for the provision of services. With regard to the extension of testing services, the project aimed to ensure provision of HIV testing at 38 service delivery sites during the period. In order to increase community access, the institutions supported by the project periodically organized mobile clinics to deliver the package of priority services, including HIV testing (outreach programs).

Table 2. HIV/AIDS Indicators

Met – 3	Number of sites offering VCT services according to norms (38 of a target of 42)
	Number of people trained in VCT (10 for target of 15)
	Number of people newly on ARVs (649 target 650)
Exceeded – 11	Number of sites offering PMTCT services according to national and international norms (31)
	Number of ARV sites (8)
	Number of pregnant women receiving VCT and getting results of tests (43,219)
	Number of people getting VCT and receiving results of tests (81,389)
	Number of HIV-positive pregnant women on prophylaxis (669)
	Number of HIV-positive people receiving palliative care, including HIV/TB co-infection (19,970)
	Number of laboratory tests (HIV, TB, syphilis) done by laboratories supported by project (245,667)
	Total number of people who ever received ARVs by end of reporting period (5,078)
	Number of providers trained in palliative care, including HIV and TB (34)
	Number of sites offering complete package of palliative care to HIV-positive persons (25)
	Number of individuals trained in laboratory services (55)
Under – 8	Number of HIV-positive persons treated for both HIV and TB (182, or 28% of target)
	Number of providers trained in PMTCT according to international norms (6 below mark of 15)
	Number of people receiving ARVs by end of reporting period (3,361 target of 3907 for the year)
	Number of health workers trained in ART (0 of 10)
	Percentage of individuals put on ARVs and still active at end of reporting period (66%)
	Number of sites offering TB treatment for HIV-positive patients (18)

	Number of infants born to HIV-positive mothers receiving care and treatment (300 or 96.5% of target)
	Number of laboratories able to perform HIV tests (38)

As a result, the project performance for the HIV/AIDS programmatic component was quite satisfactory despite the challenging context. In fact, 14 out of the 22 related indicators were met or exceeded as seen in Table 2 and presented in detail in Annex C.

Preventing Mother-to-Child Transmission of HIV

Our objectives for this year are to strengthen 22 PMTCT sites; to provide PMTCT services to 600 HIV-positive pregnant women by June 2012; to provide VCT services to 35,000 pregnant women; and, lastly, to provide HIV screening by PCR-DNA to 350 newborn from HIV-positive mothers.

The PMTCT program is one of the most successful components of SDSH; it has made great strides in achieving and even surpassing some of its objectives for the past eight months:

- 43,219 pregnant women reached out to facilities in the network and have been tested and counseled, far exceeding the 35,000 pregnant women expected for FY2011-2012;
- 1,005 pregnant women were tested with syphilis, 841 of them received appropriate treatment;
- 669 HIV-positive pregnant women received prophylactic services, exceeding our annual target of 600;
- 300 newborns from HIV-positive mothers have been tested using PCR-DNA—96% of the target thanks to the technical partnership with CARIS Foundation to strengthen pediatric AIDS services in 13 selected sites;
- Six new providers have been trained to manage HIV-positive pregnant women.

PMTCT program element challenges include those common in most developing countries: shortages of human resources (only few centers have a nurse midwife); powerful stigma, taboos, traditional beliefs, and denials associated with HIV/AIDS in the communities; and logistical and technical barriers to a formal and functional referral and counter-referral system at institutional and community levels.

To address some of these challenges, SDSH developed and implemented guidelines for community-based PMTCT. These guidelines aim to improve the integration of community health workers (health agents and trained birth assistants) into the provision of PMTCT services.

We introduced a subsidized program by providing a small stipend that covers transportation fees as an incentive for HIV-positive pregnant women to attend the four standard prenatal visits, and for TBAs to accompany women in labor to deliver at the health facilities, and to return home with the mother and the baby for postpartum care and services within 72 hours of delivery.

HIV –Clinical Palliative Care, Including HIV/TB services

The objective for HIV palliative care and support in PY5 is to provide HIV/TB palliative care (psychosocial support, opportunistic infection prevention medications, and Izoniazide), to 16,000 people living with HIV and AIDS in 24 sites. During the past eight months of this fiscal year, 25 sites provided such care to 19,970 PLHIV, exceeding targets at 125% of expected numbers (34% are men, 66% women, and 5% of

the total number are under 15 years old). Other numbers include: 34 providers from four sites trained in the management of PLHIV with HIV/TB co-infection in partnership with the PNLT; 1,421 PLWHA were newly enrolled; five new providers were trained in syphilis testing; and 29 laboratory technicians from 38 sites were trained in providing CD4 and lymphocyte count services to PLHIV under palliative care.

Among factors that contributed to this good performance, focused technical assistance was the major strategy centered on improving the quality of services, patient tracking, patient adherence, and ensuring a continuum of care from service delivery points (SDPs) at the community level, to support groups to patients' homes.

In spite of these positive accomplishments, weaknesses are still lingering within the program element. For example, most sites do not have social workers, and even when social workers are available they are not fully involved in the organization and coordination of community palliative care, but are often used as counselors. SDSH network facilities did have some stock-outs of medications in several sites; in response, the project seized the opportunity to link with SCMS for a smooth and continuous collaboration. The list of sites supported by SDSH has been shared with SCMS and an agreement reached on mechanisms to be used to ensure no future stock-outs for needed commodities. Other weaknesses observed were:

- The majority of providers have not been trained to provide support to PLHIV and their family at community level;
- Clinical palliative care is still delivered mostly at institutional level; the provision of support at community level lacks structure, creating some inefficiencies. Ideally the provision of support to PLHIV and their family at community level should be fully integrated into institutional community health services.

Moving forward to address the above challenges, SDSH planned to upgrade 18 sites to become integrated VCT/PC centers by the end of this year and to make sure social workers are hired in all those sites. SDSH is working towards a "no stand-alone VCT site" policy, enabling 80% of network SDPs to provide VCT/PC services according to MSPP norms and standards.

- All VCT/PC sites will offer community palliative care to complement institutional care;
- Coordination with other stakeholders within the community (CHAMP/PDSC) will be emphasized to ensure appropriate service delivery and to avoid duplication;
- Strengthen collaboration with LNSP (National Laboratory of Public Health) to ensure that all labs are functional;
- Providers and community health workers will be trained to acquire necessary skills to provide support to PLHIV, their loved ones, and their significant others;
- Implementation of TB as well as HIV screening using finger prick method in all community-based mobile clinics, all cases referred for appropriate management at centers, and linkages ensured between CD and CDT;
- Develop and Implement community based activities to ensure that women delivering at home and the newborn receive appropriate prophylaxis and follow-up;

- Continue the organization of VCT activities during public events such as parish fairs and Carnivals using finger prick method;
- Provide family planning services to all HIV patients to help in positive prevention;
- Increase gradually the number (from eight to 30) of sites developing and implementing methods to improve quality health services delivery using HIVQual strategy.

Antiretroviral Therapy

The objectives for antiretroviral therapy (ART) this year were to enroll 650 new eligible HIV-positive patients on ARV, provide ART care and treatment to 3,907 PLHIV, and maintain 80% of these people on treatment at the end of the period through June 2012.

By end of May, 649 new eligible HIV-positive patients were put on ART care and treatment, meeting the annual of the annual target of 650 (40% men, 60% women, and 5% of the total are younger than 15 years old). The total number of HIV-positive active patients still receiving ARV is 5,078—far exceeding the expected annual target of 4,884 (38% men, 62% women, and less than 5% of the total are younger than 15 years old).

Up until recently, the project ran only six ARV referral treatment centers throughout the network. With encouragement from USAID we are adding six new sites before the end of the project in September 2012, doubling the ART program in six months. Two sites started offering ARVs during the period under consideration: CS Lumiere/(MEBSH-FINCA) and the CAL in St Michel de l'Attalaye.

By the end of this fiscal year, four additional ARV centers of reference will be started and implemented in the West (FONDEFH-Martissant and AME-SADA), Artibonite (CAL Pierre Payen, Hosp. Claire Heureuse of Marchant Dessalines), and CMS La Fossette in the North Department. These sites will extend appropriate access to ARV care and treatment services to an additional 660,000 people living in those areas.

IIB. Tuberculosis

For this program element, the PY5 project objectives are to strengthen the 24 sites that provide TB treatment to HIV-positive patients; to provide HIV and TB treatment to 650 co-infected individuals; to train 10 providers to manage TB/HIV co-infection, and to provide VCT services to 30% of TB patients.

After more than 60 years of TB case management, Haiti still bears the highest burden of TB disease in the LAC region, aggravated by a very weak national program, endemic poverty, and often-crowded living conditions in urban and peri-urban areas. National statistics estimate at 40% the co-infection rate with HIV, which makes service integration all the more vital to the successful treatment of both diseases.

TB integration is a key result area for the program and is part of the priority package of services in SDSH's strategy to fight HIV/AIDS. Some serious systemic challenges needed to be addressed, however, given SDSH's financial limitations for the TB program we were only able to focus on the more accessible ones: the lack of trained personnel for HIV/TB integrated case management; improving labs and the TB drug supply system, (which are almost nonexistent); and addressing cultural barriers and stigma attached to TB and HIV which remain high even within the patients' families.

Results for the eight months of this fiscal year show that:

- 25 sites were fully integrated to provide services to both HIV and TB patients (reaching the annual target of 24);
- 29 providers from 29 sites were trained to screen HIV and TB, exceeding the annual target of 10 (this explains the great jump in the percentage of TB patients tested for HIV);
- 26 providers were trained in DOTS strategy;
- 4 more providers have been provided training in HIV/TB case management;
- 38 labs have been strengthened to furnish some biologic profiles for co-infected people;
- 29 lab technicians have been trained to provide necessary lab services;
- The percentage of TB patients tested for HIV has greatly increased (67% for an annual target of 30%), demonstrating that more energy was invested in the follow up of patients co-infected with TB and HIV, an area which has been lagging for a while;
- Unfortunately, only 182 individuals have been treated so far for HIV and TB (which is far below the annual target of 650);
- Case detection is assessed once a year and results are provided by the National Reference Laboratory.

Table 3. Tuberculosis Indicators

Exceeded – 4	Percentage of TB patients tested for HIV and received their test results (67% for annual target of 30%)
	Number of sites offering integrated TB services (HIV/TB) (0 for annual target of 20)
	Number of people trained in DOTS (26 for annual target of 10)
	Number of providers trained for HIV and TB testing (29 for annual target of 10)
Almost Met – 1	Number of sites offering TB treatment to HIV positive patients (18 for an annual target of 24)
Data not available --3	Percentage of laboratories doing TB microscope analysis with >95% correct results
	TB notification rate 105 per 100,000 (--)
	Percentage of expected new TB cases detected (annual target of 75%)

Overall, the project performance during this period is satisfactory and efforts to re-energize this component have yielded good results.

In future SDSH could maximize its impact on TB control by focusing its energies and resources on:

- Working with PNLT to develop and make available more IEC and health education materials for health personnel, TB/HIV patients, and the community;
- Establishing a formal partnership with PNLT to ensure availability of drugs and commodities at local level and reserved stocks for all cases diagnosed;
- Identifying, via the mapping exercises, existing TB sites and integrating them into a community network to be organized with formal referral and counter-referral systems in a bid to improve access to and use of case detection and treatment using DOTS;
- Complementing the 57 CDT and 12 CT supported by SDSH and capitalizing on their health agents to organize TB community programs around these sites to expand case detection and treatment referrals;
- Strengthening relationships with and sharing the list of all sites with SCMS to improve and ensure resolutions of gaps in the availability of related drugs and commodities;
- Replicating in selected, underserved, densely populated areas the successful community-based PIMUD/TB detection and DOTS treatment strategy;
- Ensuring effective integration of TB/HIV detection and case management at all service delivery sites and within all community level activities to reduce co-infection;
- Improving education, social communication, and community mobilization through community health workers to promote active household case detection around all TB index cases, reducing delays in accessing testing and ensuring adherence to treatment protocols;
- Strengthening TB/HIV co-infection management with other stakeholders in the community (ICC, CDS, GHESKIO, and PIH) in the 10 health departments.

IIC. Maternal Health

The program objectives for the promotion of maternal health this year are that at least 50% of pregnant women should receive at least three prenatal visits; 80% of pregnant women should have a birth plan; 100 providers will be trained in maternal and newborn health; 25 providers will be trained in long-term family planning methods; 35% of SDSH sites have at least one oversight committee for obstetric emergencies and maternal mortality rates in its service area; and 12,000 newborns are delivered with assistance from trained health personnel (excluding matrons or TBAs).

Despite various constraints encountered in implementing the action plan component of reproductive health , during the past eight months (e.g., SDMA activities, late start of mobile clinics) the main activities planned were completed. The project still has much to do to improve the health of women and thereby achieve attainment of MDGs 4 and 5, a significant reduction of maternal / neonatal mortality, and an increase in contraceptive prevalence across and throughout project institutions.

The targets were almost met or exceeded for six out of twelve indicators; SDSH was below the mark for six indicators as shown in Table 4. (See Annex C for greater detail.)

Table 4. Maternal Health Indicators

Met – 3	Percentage of pregnant women with birth plan (62% target for the period 67%)
	Number of births with trained TBA (44,926)
	Percentage of new mothers benefitting from postnatal consultation within 42 days (28%)
Exceeded – 3	Number of follow-up postnatal home visits within 72 hours of delivery (42,739)
	Percentage of pregnant women doing first prenatal visit in first trimester (38% for annual target 35%)
	Number of births with trained health worker (not including TBA) (10,694)
Under – 6 	Percentage of pregnant women receiving a second dose of tetanus toxoid (53%, annual target 70%)
	Number of prenatal visits by qualified personnel (184,426 compared to annual target of 240,000)
	Percentage of pregnant women with three prenatal visits (32%, annual target 50%)
	Number of mothers and caretakers received nutrition counseling (2,700 annual target 55,000)*
	Percentage of sites with maternal mortality committee (27%, annual target 35%)
	Number of people trained in maternal and neonatal health (38 for annual target of 100)

During this semester, the project provided technical assistance to the MSPP to revise PMTCT standards; these are ready for printing and dissemination. The Directorate of Family health (DSF) is still preparing a dissemination plan and SDSH will contribute to the printing, pending DSF's decision to do so. SDSH also supported the production of several technical guidelines or protocols (please see list that follows). We have completed and submitted these protocols for the management of obstetric emergencies, and fact sheets on managing side effects of FP methods to the DSF (MSPP) for validation. Once approved, we will avail these tools to all health facilities. Additional protocols for PMTCT and syphilis management will be developed before the end of the project. The boxes that follow show the list of the posters and protocols pending validation by DSF.

Posters:

- Initial prenatal assessment
- Targeted prenatal consultation
- Management of severe preeclampsia (PES)
- Guideline for the management of preeclampsia
- Active management of third stage of labor (AMTSL)
- Reanimation of the newborn
- Management of shock
- Protocol for the management of shock
- Handling of instruments in the context of infection prevention (IP)

Technical guidelines sheets:

- Self-breast exam
- Spotting under Combined Oral Contraception (COC)
- Migraine under COC
- Hypertension under COC
- Amenorrhea under COC
- Spotting under Oral Progesterone contraception
- Amenorrhea
- Bleeding under injectables
- Headache under injectables
- Amenorrhea under injectables
- Bleeding with implants
- Sore head with implants
- Amenorrhea under implants
- Cramping and pain with IUD

Women making their first prenatal visit during the first trimester of pregnancy at Les Anglais

IID. Reproductive Health—Family Planning and Sexually Transmitted Infections

The project's objectives for this program element were to increase access to services through the reinforcement of outreach activities such as mobile clinics and community-based distribution, and to improve service quality by building capacity at service delivery sites.

SDSH met or exceeded its targets for most RH indicators (8/12) during this period and was below the mark for three indicators as shown in Table 5. No target was set for one indicator. (See Annex C for greater detail.)

Table 5. Family Planning/Reproductive Health Indicators

Met – 3	Number of CYP (208,241)
	Percentage of sites offering at least 5 FP methods with at least two long term (51% of annual target 55%)
	Percentage of people of RH age using modern FP method (30%)
Exceeded – 5	Number of people trained in FP/RH (75, annual target 50)
	Number of staff trained in long-term FP methods (35 for a target of 25)
	Number of service sites offering FP counseling and services , long-term and permanent methods (154)
	Number of sites with strengthened MIS (157 annual target 147)
	Percentage of Depo-Provera users who get their next injection on schedule (93% annual target 90%)
Under – 3	Percentage of FP users using a long-term modern method (10% target 14%)
	Number of new FP users (143,700 annual target 170,000)
	Number of new cases of STIs detected and treated (22,981)
No Target – 1	Number of guides or manuals elaborated or revised to improve access or use of FP/RH services

It should be recognized that the project succeeded in increasing the number of service providers able to offer long-term methods in the network. A total of 110 providers from 75 institutions were trained in FP/RH procedures, particularly long-term methods and the reinforcement of client follow-up. User retention increased, as shown in Table 5 (93% Depo-Provera users received their next injection on time).

The SDSH program has also made great progress compared to last year reaching close to 89% of the expected results for new users of modern methods, representing 143,700 of which 55,267 (38%) are men and 64,154 (45%) are younger than 25 years old. Although the project achieved satisfactory results, it is worth noting that the provision of modern FP methods in the network remains insufficient; only 51 percent of service delivery points are offering five modern family planning methods including at least two long-term methods.

The challenges encountered last year remain: lack of adequate detection and treatment of sexually transmitted infections (STIs) due to passive interventions for STI detection, lack of medicines to treat STIs, limited capacity for case diagnosis and management of STIs, and inadequate coordination with departmental teams for the promotion and provision of long-term FP methods (especially for the organization of mobile clinics where mobilizing some categories of staff from the departmental team require additional funding). The project leadership discussed this issue with departmental directors, who promised to facilitate the implementation of the FP mobile clinics.

IIE. Child Health

Child health promotion has been one of the best performing result areas: child immunization has generally exceeded 85% since the introduction of the PBF mechanism. However, since the beginning of the FY12 up to May 2012, only 58 percent of infants 0–11 months were completely vaccinated compared to 96% by the end of Project year 4. Also only 85,873 (or 89%) children aged 0–11 received DTP3, falling short of an expected 96,218 for the period. The reasons behind this poor performance include the stock out of antigens and supplies. Many partners reported stock-outs of polio vaccine, a fact that was confirmed by the national EPI program (DPEV). The change in the supply system of vaccines and related supplies from UNICEF to the Brazilian cooperation did not go smoothly, causing shortages of antigens for vaccination and especially the propane gas (used to maintain the cold chain) in mid- January 2012.

From January to May 2012, SDSH staff supported the MSPP in organizing and implementing vaccination campaigns led by MSPP. In its effort to improve child survival and child health by controlling, eliminating, or eradicating vaccine preventable diseases, the MSPP (through the national Expanded Program for Immunization), and the Family Health and Nutrition directorates launched massive activities throughout the country during the months of April and May. MSPP's goal was to vaccinate approximately 2.5 million children nine years old and younger against polio, and 2.3 million ages nine months to nine years against measles and rubella. In addition, health providers were also expected to administer about 1.2 million doses of vitamin A and 2 million doses of Albendazol, a de-worming drug. USAID,UNICEF, PAHO/WHO, CIAD, and the *Projet Tripartite* are just a few supported this initiative.

Table 6. Child Health Indicators

Met – 4	Percentage of weighings for children <5 years of age that show evidence of severe malnutrition (2%)
	Percentage of weighings for children <5 years that show high risk of severe malnutrition (7%)
	Percentage of weighings for children <5 years of age that indicate a weight-to-age ratio equivalent to low weight-for-age or very low weight-for-age (9%)
	Number of infant pneumonia cases treated with antibiotics (8,224 annual target 10,000)
Exceeded – 4	Number of children reached by nutrition program (413,890)
	Number of children <5 years who received vitamin A (311,829 expected for the period 302,222)
	Number of mothers and caretakers trained in diarrhea prevention (32,268)
	Number of mothers and caretakers trained in diarrhea management (31,760)
Under – 4	Number of children who received two doses of vitamin A (147,524)
	Percentage of infants 0–11 months completely vaccinated (58%)

Number of children ages 0–11 with DTP3 (85,873)
Number of people trained in child health care and nutrition (72 annual target 300)

SDSH met or exceeded in eight out of the twelve selected indicators as shown in Table 6.

SDSH was involved at all levels from participation to the inter-agency consultation meetings, to the organization of field activities through the health technical advisors embedded in the health department offices, and social mobilization through community health agents. The 1,544 community health agents working for the network's 160 health facilities who were mobilized throughout the 10 departments were critical to the organization and actual provision of services during the 2012 Intensive Child Health Activities (*Activités Intensives en Santé Infantile* – AISE-2012).

The SDSH Project has also facilitated the donation of five million syringes through Direct Relief International (DRI). Preliminary results show that for a total population of 2,018,070 children (ages 0-9 years) in the network, a total of 581,666 children received polio vaccine exceeding the objective of 532,569. The best results were among the age group of 0-11 months with 66,419 for an expected 54,488. Similar levels of success were observed for measles and rubella. The distribution of vitamin A and Albendanzol were successful at 95% of the objectives. Detailed results will be found in the child health week report.

Apart from the organization of the immunization campaigns, the project continued technical assistance interventions through working groups to revise of IMCI norms. SDSH supported North and Center departments to revive Mothers' Clubs by conducting orientation sessions and reproducing education materials for these groups

III. Other Domains

During this first semester, the strategic partnerships component of SDSH remained very strong, exceeding by far the two indicators tracked in the PMP. The percentage of leveraged contributions covered over the life of the project has increased by fourfold. The project continued the partnership with DRI and Pure Water for the World (PWW) to leverage additional resources and substantial in-kind support to strengthen its interventions and respond to the needs of the target population.

New agreements have been signed between SDSH and PWW for the provision of safe water to a new group of 450 schools, 50 health sites, and at least 200 households in the project catchment areas before June 30, 2012. As of now, more than 125 000 school children and their families have access to safe water. The assumption that this translates to a significant reduction in water-borne diseases among the children and a greatly improved school attendance is supported by extensive scientific evidence in the literature.

In addition, knowledge and skills transfer have enabled a great number of Haitian teachers and workers to guide and oversee this program since the beginning of this partnership. For this period, training has been offered to 20 lab technicians for periodic water testing and site inspection, and to 1,000 animators teaching better hygiene practices with appropriate adapted materials, while 30 workers have mastered the craft of building concrete filters using local raw materials.

During this semester, the project signed a new agreement with DRI, and Konbit Santé (KS). The main objective of this new memorandum was to strengthen the maternal health component by increasing access to and utilization of quality obstetric and neonatal care, with a special emphasis on the program's PMTCT component. To that end, eight sites have been selected to be upgraded into "centers of excellence" with the capacity to offer the full range of services to pregnant women and their newborn, particularly those from HIV-positive mothers. More than half a million people could be reached by this intervention, as well as thousands of pregnant women living in remote areas near those sites.

The value of this operation is over a million dollar and the eight sites will receive specialized equipment and other supplies such as birthing beds, delivery kits, hospital beds, equipment for C-sections and other obstetrical emergencies, and anesthesia machines.

Overall, SDSH met or exceeded five of the indicators tracked for the life of the project under this component of the project and was below the mark for three indicators as shown in Table 7. No target was set for one indicator. (See Annex C for greater detail.)

Table 7. Other Indicators

Met– 1	Percentage of the population served by project as of September 30, 2011 (42% compare to approximately 50% annual target)
Exceeded- 4	Percentage of matching fund covered (> 400%)
	Number of sites having BCC and information on basic health services (157)
	Number areas where at least one site (school or orphanage, health center, household) has clean water (450 schools and orphanages, 200 households, and 50 service sites)
	Number of grants under contract awarded (12) and 87 subgrants
Under – 3	Number of success stories transmitted to USAID (6 target of 12)
	Number of SDSH sites visibly showing USAID sign/logo (--)
	Number of active local health task forces (0, annual target of 40)
No Target – 1	Number of highly visible events organized (done on an as-needs-arise basis)

SDSH Communication and Public Relations

Public Events, Site Visits, Success Stories, and Branding

Communications activities during the first semester of PY5 comprised the organization of sites visits by USG and other teams. Preparations include production of fact sheets, ensuring branding is respected at health facilities, and conducting the actual visit. SDSH hosted Ms. Eileen Smith of the State Department for a visit to SADA Matheux and Bercy health center in March 2012. The project also facilitated the visit of Mr. Feirstein and Ms. Hogan with USAID Haiti team, they were in country for a rapid appraisal of the public financing systems at the community clinic of FONDEFH Martissant. In this visit, SDSH demonstrated that operations were in good order, and that the center was totally managed by a team of Haitian nationals offering free quality services to the population, a sign that the money from the American people was put to a good use with great potential for sustainable systems because of the local ownership of the program.

SDSH submitted six success stories to the communications officer during the period under consideration and lastly, the project leadership team met with the new Minister for Health and Population to find out

about her expectations and priorities with regard to the project mandate. The following priorities were agreed upon: repositioning family planning; expanding the PBF approach for a national scope, and, as a result setting up a PBF Management Unit in MSPP; strengthening health systems with a specific focus on improving strategic planning and management of health programs; strengthening health decentralization; strengthening the HMIS; developing a health financing policy framework; improving the management of medicines and health technologies; strengthening the human and institutional capacity to deliver efficiently on health programs; and strengthening donor coordination in health to ensure complementarities and greater efficiency in managing health interventions. These have been integrated into the revised milestones plan.

SDSH Project Management

The Management Unit provided strong leadership to ensure a successful implementation of the project. New initiatives were approved and integrated in the program such as the organization of mobile VCT clinics around the Carnival feasts in February, the start up of six new ARV sites and the development of referral networks which represented USAID's new priorities. The Management Team worked closely with SDSH Contracts Unit in the preparation of all award documents for SDSH partners, providing the list of objectives, expected deliverables, disbursement schedules, and the amount of performance-based award fees, or bonus payments, to meet select indicators.

Project Staffing

Challenges with staffing, especially in leadership positions, inherited from the previous period continued at the beginning of the semester with the third Chief of Party resignation occurring at the end of October. By December 2011, a new Chief of Party, Dr. Kathy Kantengwa and a new Technical Director and Deputy Chief of Party, Dr. Serge Conille were approved by USAID. The project received support from the MSH Chief Operations Officer who facilitated a realignment workshop for the new team but also an opportunity to review the project priorities in light of the new expectations from the MSPP incoming administration.

Besides the leadership positions, all other vacant positions were filled during this period either with full-time staff or long-term consultants to carry out the implementation of project activities. In total, 10 new personnel were recruited during this first semester. With a reinforced and revitalized workforce, the project is confident that it is achieving and at times exceeding the level of results envisioned in the PMP.

Infrastructure Renovation Work

The Project supported renovations for the West Departmental Directorate, targeting repairs for the ceiling and acquisition and installation of air conditioners. The ceiling has been renovated while the procurement process of air conditioners is still in progress. The following activities were also carried out:

- Assessment of rehabilitation needs to turn Bercy from a health center without beds to a functional health center with beds, primarily for maternal health services, and with a unit for stabilization of trauma injuries.
- KHOLER 80kw generator was repaired and returned to DSC.
- BERACA, Hopital Claire Heureuse, ZC Ile-A-Vache, and ZC La Tortue were visited to evaluate the renovation needs before the distribution of hospital equipment donations to be made by DRI.

- Supervisory visits of the following renovated sites have been conducted to verify the completion of work: ZC Borgne, ZC Dondon, ZC Saint Raphael, and Centre de Santé Ranquitte.
- Costs estimate for the rehabilitation prepared for the new ARV centers: Hopital Claire Heureuse, Centre de Santé Pierre Payen, MEBSH, CDS, SADA, FONDEFH, and ZC Saint Michel.

Conclusions: Challenges and Perspectives

The SDSH Project is now in its fifth and final year, and less than a quarter remains to be completed. The SDSH team has demonstrated strong leadership and a tremendous capacity to adapt to new demands and rapidly changing situations. Despite all the challenges, SDSH has reached or exceeded the majority of its indicators, and partners were able to deliver essential services to approximately half of Haiti's population. The focus during the period of October 01, 2011 to May 30, 2012 has been on improving the quality of services, starting with the SDMA assessment from November 2011 to January 2012 that revealed that many sites lack adequate infrastructure and capacity to organize and deliver quality health services. We do hope that the interventions to build the capacity of health providers in partner institutions in each department will yield visible results by the end of the project, and enhance the provision of quality services. SDSH leadership received USAID's external mid-term evaluation report towards the end of March, and is working diligently to address short-term recommendations from that report. These were addressed specifically to the project for quick adjustments before the end of the year.

The major challenge for the remaining period is to ensure a smooth transition between SDSH close-out and the Bridge mechanism start-up projected to begin on July 1 and last for one year. A smooth transition will preserve the provision of services to the populations most in need. The process of renewing local subcontracts is very tedious and time-consuming. The project must develop terms of reference, brief partner organizations through stakeholder meetings, set targets and budget ceilings for each partner, receive and analyze work plans from partner institutions, provide feedback on activities and budgets, negotiate contracts, submit requests for USAID approval for some subcontracts, and finally sign the contracts and agreements for more than 160 institutions. It takes, on average, at least three and one-half months from start to finish. The project team has been amazing juggling competing priorities and trying to ensure nothing fall; we welcome the new Bridge mechanism that will allow more time to further improve the quality of services and address some of the recommendations from the USAID evaluation to ensure the transfer of project capacities to the MSPP departmental directorates.

ANNEXES

Annex A: SDSH Partners performance for PY4 (October 2010-September 2011)

	NGOs	Percentage of Prime & Award earned
1	Clinique Dugué	6%
2	Konbit Sante	1%
3	CBP	2%
4	BERACA	3%
5	CDS	5%
6	SADA	5%
7	OBCG	4.8%
8	ICC/GCH	4%
9	CENTRE DE SANTE ROSALUE RENDUE	1%
10	CENTRE DE SANTE LUCILIA BONTEMPS	6%
11	CLINIQUE SAINT PAUL	1%
12	FONDEFH	5%
13	OBDC	1.2%
14	HOPITAL SAINTE CROIX	0%
15	HOPITAL CLAIRE HEUREUSE	1%
16	CENTRE DE SANTE PIERRE PAYEN	2%
17	HOPITAL ALBERT SCHWEITZER (HAS)	1.25%
18	SAVE THE CHILDREN	2%
19	MEDISHARE	0%
20	HOPITAL FERMATHE	2.5%
21	CENTRE DE SANTE SACRE CŒUR DE THIOTTE	0%
22	CLINIQUE LA FANMY	0%
23	MEBSH	4%
24	HHF	5%
25	CENTRE DE SANTE SAINTE HELENE	5%
26	CENTRE DE SANTE LEON COICOU	1.25%
27	AEADMA	6%
N.B.: Validation results for FOSREF are not yet submitted.		
ZONES CIBLÉES		
1	ZC SAINT RAPHAEL	2.5%
2	ZC DONDON	0.5%
3	ZC BORGNE	1%
4	ZC ANSE-A-FOLEUR	3%
5	ZC BAIE DE HENNE	6%
6	ZC LA TORTUE	1.5%
7	ZC VALLIERES	5%
8	ZC CARICE	4%
9	ZC MOMBIN CROCHU	3%

10	ZC PERCHES	2%
11	ZC SAINTE SUZANNE	5%
12	ZC BELLADERE	3%
13	ZC SAVANETTE	3%
14	ZC BAINET	2.5%
15	ZC LES ANGLAIS	3%
16	ZC ILE-A-VACHE	2.5%

Annex B: SDSH Partners

MSPP/ZCs	NGO Partners
Artibonite	
Gonaïves; CS Saint Michel; CS de Marmelade; CS de Grande Saline N=4	Hôpital Albert Schweitzer; Hôpital Claire Heureuse; CS Pierre Payen N=3
Centre	
CS de Belladère; CS Cerca la Source; CS Savanette N=3	Save the Children; Medi-Share N=2
Grand Anse	
CS des Abricots; CS de Corail N=2	Haitian Health Foundation; Ste Hélène; Léon Coicou H.C.; AEADMA (Association d'Entr'Aide des Dame-Mariens) N=4
Nippes	
CS de L'Azile; CS de Petit Trou; CS de L'Anse à Veau N=3	None N=0
North	
CS de l'Acul; CS de Borgne; CS de Dondon; CS de Saint Raphaël N=4	CBP; Dugué Clinic; CDS; Konbit Santé N=4
North-East	
CS de Mombin Crochu; CS Ste Suzanne; CS Vallières N=3	CDS North-East[1]
North-West	
CS La Tortue; CS Baie de Henne; CS Anse à Foleur N=3	Beraca Medical Center N=1
West	
CS Belle Fontaine; CS Cornillon; CS Aurore du Bel Air; CS de Tayfer ; Thomazeau ; Tayfer ; Cite Soleil N=7	St. Paul Clinic; CSNRR (Filles Charité); FONDEFH; FOSREF; Fermathe Hospital; Grace Children's Hospital; OBCG; SADA; CS Lucélia Bontemps; OBDC; Hopital St. Croix N=11
South	
CS Les Anglais; CS de l'Ile à Vache N=2	La Fanmy; MEBSH N=2
South-East	
CS de Baînet N=1	Sacré Cœur de Thiotte Health Center N=1
Total ZCs: N=33	**Total NGOs: N=28**

[1] CDS, CDS North East and CDS Ouest are counted as 1 institution

Annex C: SDSH Semi-Annual Results for FY12 (October 2011-May 2012)

Indicator Code	Indicator	Unit of Measure	Annual Objective	Results Oct 2011 to May 2012	Comments
HIV/AIDS					
3.1.1.9 (F)	Number of sites offering the minimum package of PMTCT services according to national and international standards	#	22	31	Exceeded target
3.1.1.10 (F)	Number of pregnant women who received HIV counseling and testing for PMTCT and received their test results	#	35,000	43,219	Exceeded target
3.1.1.10. c	Number of newborns of HIV-positive mothers benefiting from pediatric care	#	350	300	Achieved 96.5%
3.1.1.11	Number of diagnosed HIV-positive pregnant women having received ARV prophylaxis in a PMTCT setting	#	600	669	Exceeded target
3.1.1.12 (F)	Number of health workers trained in the provision of PMTCT services according to national and international standards	#	15	6	Below target
3.1.1.13 (F)	Number of sites providing counseling and testing according to national and international standards	#	42	38	Target met
3.1.1.14 (F)	Number of people who received counseling and testing for HIV and received their test results	#	70,000	81,389	Exceeded target
3.1.1.16 (F)	Number of people trained in counseling and testing (training to be done by another agency—targets set by implementing agency with direct financing by USAID)	#	15	10	
3.1.1.17 (F)	Number of sites providing ART	#	6	8	Exceeded target
3.1.1.18 (F)	Number of people newly placed on ARV during the reporting year	#	650	649	
3.1.1.18. a	Number of individuals who have received ART during the year	#	4,884	5,078	
3.1.1.19 (F)	Number of people receiving ART at the end of the reporting period	#	3,907	3,361	

Indicator Code	Indicator	Unit of Measure	Annual Objective	Results Oct 2011 to May 2012	Comments
3.1.1.19. a	Percentage of individuals placed on ARV and found still in active treatment at the end of the reporting period	%	80%	66%	
3.1.1.20	Number of health workers trained to deliver ART services (training to be done by another agency—targets set by implementing agency with direct financing by USAID)	#	10	---	
3.1.1.21 (F)	Number of sites providing treatments for TB to HIV-positive patients	#	24	18	
3.1.1.22 (F)	Number of people provided with HIV-related palliative care (including those co-infected with TB and HIV)	#	16,000	19,970	
3.1.1.22. a	Number of sites offering a complete clinical package of palliative care to HIV-positive people	#	24	25	
3.1.1.23 (F)	Number of HIV-positive individuals receiving treatment for both TB and HIV	#	650	182	
3.1.1.24 (F)	Number of people trained to provide HIV palliative care (including TB/HIV co-infection)	#	10	34	
3.1.1.29 (F)	Number of laboratories with capacity to perform (a) HIV tests and (b) CD4 tests and lymphocyte tests, or all three	#	42	38	
3.1.1.30	Number of people trained in the provision of laboratory-related services (training to be done by another agency—targets set by implementing agency with direct financing by USAID)	#	10	55	
3.1.1.31 (F)	Number of tests performed at supportive laboratories: (a) HIV testing (b) TB diagnostics (c) Syphilis testing (d) HIV disease monitoring	#	193,800	245,667	
Tuberculosis					
3.1.2.1 (F)	Tuberculosis notification rate	#/100K inhabitants	105 for 1,000	---	

Indicator Code	Indicator	Unit of Measure	Annual Objective	Results Oct 2011 to May 2012	Comments
3.1.2.1. a	Tuberculosis detection rate	%	32%	---	
3.1.2.3 (F)	Number of people trained in DOTS	#	10	26	
3.1.2.4 (F)	Percentage of TB patients who were tested for HIV and received their results	%	30	67	
3.1.2.4. a	Number of TB patients who were tested for HIV and received their results	#			
3.1.2.5 (F)	Percentage of laboratories performing TB microscopy with over 95% correct microscopy results (quality control testing to be performed by the national laboratory within its mandate)	%	>95%	---	
3.1.2.6. a	Number of sites offering integrated TB services *(only detection with referral for treatment)*	#			
3.1.2.6. b	Number of people trained in TB and HIV testing	#	10	29	
3.1.2.7 (F)	Percentage of expected new TB cases detected	%	75%	---	
Maternal Health					
3.1.6.3 (F)	Number of postpartum newborn visits during the 3-day interval following child birth	#	40,000	42,739	
3.1.6.4 (F)	Number of prenatal care visits with skilled providers	#	240,000	184,426	
3.1.6.4. a	Percentage of pregnant women having the first prenatal visit during the first trimester of pregnancy	%	35%	38%	
3.1.6.4. b	Percentage of pregnant women who have had at least three prenatal visits	%	50%	32%	
3.1.6.4. c	Percentage of pregnant women who have received a second dose or a recall dose of tetanus vaccine	%	70%	53%	
3.1.6.4. d	Percentage of pregnant women making a birth plan	%	75%	62%	

Indicator Code	Indicator	Unit of Measure	Annual Objective	Results Oct 2011 to May 2012	Comments
3.1.6.5 (F)	Number of people trained in maternal and newborn health (women and men)	#	100	38	
3.1.6.6 (F)	Number of deliveries with a skilled birth attendant—TBAs not included	#	10,000	10,694	
3.1.6.6. b	Number of deliveries with assistance of a health facility–based skilled birth attendant	#	50,000	44,926	
3.1.6.6. c	Percentage of new mothers who have had postnatal consultations	%	33%	28%	
3.1.6.6. d	Percentage of sites that have at least one maternal health committee in their service area	%	35%	27%	
3.1.6.6. g	Number of mothers and child caretakers having received nutritional counseling	#	55,000	2,700	
Child Health					
3.1.6.2	% of children 0–11 months completely vaccinated	%	85%	58%	
3.1.6.7 (F)	Number of people trained in child health and nutrition.	#	300	72	
3.1.6.11 (F)	Number of children reached by nutrition programs	#	345,000	413,890	
3.1.6.11. a	Percentage of weighings for children <5 years of age that indicate a weight-to-age ratio equivalent to low weight-for-age, very-low-weight for age.	%	12%	9%	
3.1.6.11 .b	Percentage of weighings for children <5 years of age that show evidence of severe malnutrition	%	3%	2%	
3.1.6.11. c	Percentage of weighings for children <5 years of age that show high risk of severe malnutrition	%	9%	7%	
3.1.6.12 (F)	Number of children <12 months who received DPT3	#	108,245	85,873	
3.1.6.13 (F)	Number of children <5 years of age who received vitamin A	#	340,000	311,829	

Indicator Code	Indicator	Unit of Measure	Annual Objective	Results Oct 2011 to May 2012	Comments
3.1.6.13. b	Number of children <5 years of age who received two doses of vitamin A	#	200,000	147,524	
3.1.6.14. a	Number of mothers and child caretakers trained about diarrhea prevention (exclusive breastfeeding, pure drinking water, and hygiene)	#	20,000	32,268	
3.1.6.14. b	Number of mothers and child caretakers trained in diarrhea management (danger signs and oral rehydration)	#	20,000	31,760	
3.1.6.19 (F)	Number of cases of pneumonia in children <5 years of age treated with antibiotics	#	10,000	8,224	
Reproductive Health/Family Planning					
3.1.7.2 (F)	Total number couple-years of protection (CYP)	#	240,000	208,241	
3.1.7.3 (F)	Number of people trained in FP/RH (women and men)	#	50	75	
3.1.7.3. a	Number of people trained in offering longer-term FP methods	#	25	35	
3.1.7.6 (F)	Number of policies or guidelines developed or changed to improve access to and use of FP/RH services	#	---	---	
3.1.7.8 (F)	Number of service delivery points offering FP counseling or services for long-term or permanent methods	#	142	154	
3.1.7.8 a	Percentage of sites offering at least five FP methods, of which two are longer term	%	55%	51%	
3.1.7.12 (F)	Number of sites in which the MIS system has been reinforced	#	147	157	
3.1.7.13 (F)	Percentage of users of long-term contraceptive family planning methods	%	14%	10%	
3.1.7.13. a	Percentage of people of reproductive age using a modern contraceptive method (for FP)	%	30%	30%	
3.1.7.13. b	Percentage of Depo-Provera users who respect the replenishment delays	%	90%	93%	

Indicator Code	Indicator	Unit of Measure	Annual Objective	Results Oct 2011 to May 2012	Comments
3.1.7.13 c	Number of new family planning users	#	170,000	143,700	
3.1.7.14	Number of new cases of STI detected and treated	#	35,000	22,981	
Strengthening MSPP Executive Functions					
FE.1	Number of health departments with donor coordination mechanism	#	6	6	
FE.2.a	Percentage of departments implementing approved operational plan	%	100%	---	
FE.3.a.	Number of departments implementing supervision plan for service delivery	#	10	8	
FE.4	Number of ZCs funded with PBF	#	29	33	
FE.4.a.	Number of ZCs benefitting from basic package of services supported by SDSH	#	31	33	
FE.5	Number of departments with new financial and accounting mgmt system set up and in use	#	10	7	
FE.6	Number of communes with ZCs where info system for services is set up and in use	#	31	33	
FE.7	Number of departments supported to operationalize the national HIS	#	6	---	
Other					
AD.1	Percentage of population served by project (as of March 31, 2011)	%	50%	42%	
AD.5	Percentage of matching funds covered	%	100%	---	
AD.6	Number of areas where at least one site (school or orphanage, households, health center) has clean water	#	---	---	
AD.7	Number of highly visible events organized	#	---	---	
AD.8	Number of success stories transmitted to USAID	#	12	---	
AD.9	Number of SDSH sites visibly showing USAID sign/logo	#	147	89	

Indicator Code	Indicator	Unit of Measure	Annual Objective	Results Oct 2011 to May 2012	Comments
AD.9.a	Number of active Local Health Task Forces	#	50	---	
AD.10	Number of sites having BCC and information on basic health services	#	147	---	
AD.12	Number of grants under contract awarded	#	25	---	

Annex D:

SDSH
Liste des institutions de services et PPS par Département

JUIN 2012

					SERVICES OFFERTS								
Département	**ONGs**	**Sites / PPS**	**Commune**	**Pop. 2011-2012**	SM	SI	PF	CDV	Soins palliatifs	ARV	PTME	TB (CDT)	TB (CT)
Artibonite				**114,772**									
	HAS	Deschapelles	Verrettes	33,623	√	√	√					√	
		Liancourt	Verrettes	43,522	√	√	√						
		Tienne	Verrettes	15,474	√	√	√						
		Bastien	Verrettes	22,153	√	√	√						
	HCH			**151,071**									
		Claire Heureuse	Dessalines	16,118	√	√	√	√	√		√	√	
		La Croix	Dessalines	21,362	√	√	√						
		Célio	Dessalines	20,772	√	√	√						
		Niel	Dessalines	23,506	√	√	√						
		Déseaux	Dessalines	25,288	√	√	√						
		Poste Pierrot	Dessalines	7,644	√	√	√						
		Grande Hatte*(Act. Comm.)	Dessalines	7,644	√	√	√						
		Coupe-à-L'inde	Dessalines	7,644	√	√	√	√					
		Sanoix	Dessalines	21,090	√	√	√						
	Ppayen	CS de Pierre Payen	Saint Marc	**35,748**	√	√	√	√	√		√	√	

				72,176										
	Medishare	Marmont	Hinche	16,712	√	√	√							
		Casse	Thomonde	55,464	√	√	√							
				48,298										
Centre		Bourg de Maïssade	Maissade	15,850	√	√	√	√	√		√	√		
	SAVE	Ossenande	Maissade	12,445	√	√	√							
		Cinquième	Maissade	7,887	√	√	√							
		Selpêtre	Maissade	12,116	√	√	√							
				167,611										
	HHF	Klinik Pèp Bondyé	Jérémie	137,997	√	√	-	√	√		√			
		Klinik St Joseph	Jérémie	29,614	√	√	-							
G'Anse	**Ste Hélène**	CS de Ste Hélène	Jérémie	**37,525**	√	√	√	√	√		√			
	L.Coicou	CS Léon Coicou	Abricots	**12,364**	√	√	√					√		
	AEADMA	CAL de Dame Marie	Dame Marie	**29,668**	√	√	√	√	√	√	√	√		
				72,513										
	CBP	Hôp. de Pignon	Pignon	38,490	√	√	√	√	√	√	√	√		
		CS La Victoire	La Victoire	9,376	√	√	√						√	
Nord		CS Ranquitte	Ranquitte	24,647	√	√	√					√		
	Dugué	CMC Dugué	Plaine du Nord	**63,516**	√	-	√	√	√		√			
	CDS Nord	CS La Fossette	Cap-Haïtien	**138,251**	√	√	√	√	√		√	√		
	Konbit Sante	Fort St Michel	Cap-Haïtien	**41,951**	√	√	√					√		
				173,245										
N'Est	**CDS N'Est**	Hôp.de Fort Liberté	Fort-Liberté	32,739	√	√	√	√	√	√	√	√		
		CMS Ouanaminthe	Ouanaminthe	101,297	√	√	√	√	√	√	√	√		

		CMS Mont Organisé	Mont-Organisé	20,324	√	√	√					√	
		Disp. Capotille	Capotille	18,886	√	√	√						√
N'Ouest	**Beraca**	CAL de Beraca	Port-de-Paix	**44,579**	√	√	√	√	√	√	√	√	
Sud	**La Fanmy**	Cl. La Fanmy	Cayes	**33,918**	√	-	√	√					
	MEBSH			**72,301**									
		Plaisance	Plaissance	13,183	√	√	√						
		Labiche	Cavaillon	17,468	√	√	√						
		Changieux	L'Asile	8,358	√	√	√						
		Bonne Fin	Cavaillon	5,810	√	√	√	√	√		√	√	
		Marc	Cavaillon	4,308	√	√	√						
		CS Lumière	Cayes	23,174	√	√	√	√	√	√	√	√	
Sud'Est	**Sacré Coeur**	CS Sacré Coeur	Thiotte	**31,845**	√	√	-						
Ouest	**St Paul**	CS St Paul	Arcahaie	**36,949**	√	√	√	√	√		√	√	
	Filles Charité	CNSRR	Cité Soleil	**48,885**	√	√	-	√					
	FONDEFH			**579,797**									
		CS Cité Canada	Port-au-Prince	60,799	√	√	√					√	
		Cl.Co. Canapé Vert	Port-au-Prince	54,043	√	√	√					√	
		Cl.Co.Martissant	Port-au-Prince	135,109	√	√	√	√	√		√	√	
		CS Bizoton	Carrefour	33,778	√	√	√					√	
		CS ADCEF	Port-au-Prince	54,043	√	√	√						
		CS Main Tendue	Carrefour	33,778	√	√	√						
		CC Delmas 75	Delmas	54,043	√	√	√	√	√		√	√	
		Pétion Ville	Pétion-Ville	74,313	√	√	√						
		Ste Elizabeth	Port-au-Prince	54,043	√	√	√						

	CS Morne Lazarre	Pétion-Ville	25,850	√	√	√							
FOSREF			**348,286**										
	CEGYPEF	Port-au-Prince	149,930	√	-	√	√			√			
	C.Christ-Roi	Delmas	112,138	√	-	√	√						
	C.Solino	Delmas	86,218	√	-	√	√						
Fermathe			**59,283**										
	Hôp.de Fermathe	Kenscoff	29,581	√	√	√	√			√	√		
	Disp.Greffin	Pétion-Ville	14,206	√	√	√							
	Disp.Robin	Pétion-Ville	8,891	√	√	√							
	Disp.Bolosse	Kenscoff	6,604	√	√	√							
ICC Grace	ICC Grace	Delmas	**69,784**	√	√	√	√	√	√	√	√		
OBCG	CS OBCG	Carrefour	**64,080**	√	√	√	√						
SADA			**122,872**										
	Matheux	Arcahaie	61,726	√	√	√	√	√		√	√		
	Source Matelas	Cabaret	18,247	√	√	√							
	Bellanger	Cabaret	25,787	√	√	√							
	Fonds Baptiste	Arcahaie	17,112	√	√	√							
Ste Croix			**167,682**										
	Hop Ste Croix	Léogane	55,795	√	√	√							
	Beausejour	Léogane	2,882	√	√	√							
	Centre M. Infantil	Léogane	40,664	√	√	√							
	Darbonne	Léogane	35,978	√	√	√							
	Fonds d'Oies	Léogane	7,628	√	√	√							
	Palmiste a Vin	Léogane	10,870	√	√	√							

		Petit Harpon	Léogane	5,472	√	√	√							
		Trouin	Léogane	8,392	√	√	√							
	L.Bontemps	CS L.Bontemps	Croix des Bouquets	**42,866**	√	√	-	√					√	
	CDS Ouest	CS PPC	Delmas	**29,794**	√	√	√						√	
				96,194										
	OBDC	CSL Grenier (Laboule 12)	Petion-Ville	16,358	√	√	√							
		CSL Laboule	Petion-Ville	16,516	√	√	√							
		CSL Jalousie	Petion-Ville	63,320	√	√	√							
Total ONG	**28 ONGs**	**81 sites**		**3,007,821**										

ZONES CIBLEES

Département	**ZC**	**Sites / PPS**	**Commune**		SM	SI	PF	CDV	Soins palliatifs	ARV	PTME	TB (CDT)	TB (CT)
Artibonite	**Gonaïves**			**167,933**									
		Raboteau	Gonaives	28,680	√	√	√	√			√	√	
		K-Soleil	Gonaives	27,526	√	√	√					√	
		La Branle	Gonaives	10,618	√	√	√						
		Bayonnais	Gonaives	22,700	√	√	√						
		Bassin	Gonaives	50,052	√	√	√						
		Poteau	Gonaives	15,369	√	√	√						
		Pont Tamarin	Gonaives	12,989	√	√	√						
	St Michel			**112,791**									
		CAL St Michel	St. Michel	21,234	√	√	√	√	√	√	√	√	
		PS Lattalaye	St. Michel	11,455	√	√	√						

		PS Platana *(Act. Comm.)	St. Michel	11,228	√	√	√						
		Camathe	St. Michel	8,885	√	√	√						
		Marmont	St. Michel	16,023	√	√	√						
		Bas de Sault	St. Michel	9,937	√	√	√						
		Lermithe	St. Michel	8,226	√	√	√						
		Lacidras	St. Michel	12,108	√	√	√						
		Lalomas	St. Michel	13,694	√	√	√						
	Marmelade	CS De Marmelade	Marmelade	**29,587**	√	√	√	√	√		√	√	
	Grande Saline	Bérée de Drouin	Grande Saline	**17,698**	√	√	√						
Centre	**Belladère**			**68,054**									
		Hôp. de Belladère	Belladère	46,147	√	√	√					√	
		Disp.de Baptiste	Belladère	17,049	√	√	√					√	
		Disp. Roy Sec	Belladère	4,858	√	√	√						
	Cerca la Source			**48,983**									
		Centre de Cerca La Source	Cerca-la-Source	40,161	√	√	√					√	
		Disp.de Tilory	Cerca-la-Source	8,822	√	√	√					√	
	Savanette			**36,146**									
		Centre de Savanette	Savanette	29,008	√	√	√					√	
		Disp. De Colombier	Savanette	7,138	√	√	√						
G'Anse	**Abricot**	CS Abricots	Abricots	**19,885**	√	√	√	√	√		√	√	
	Corail	CS de Corail	Corail	**24,085**	√	√	√					√	

Nippes	**L'Azile**			**22,569**									
		CS de L'Azile	L'Azile	13,046	√	√	√	√	√		√	√	
		Disp. Changieux	L'Azile	5,310	√	√	√						
		Disp. Morisseau	L'Azile	4,213	√	√	√						
	Petit Trou			**30,166**									
		CS Petit Trou	Petit Trou	25,267	√	√	√	√			√	√	
		Disp. Grand Boucan	Petit Trou	4,900	√	√	√						
	Anse A Veau			**46,618**									
		CS Jules Fleury	Anse à Veau	18,988	√	√	√	√	√		√	√	
		Disp. Arnaud	Anse à Veau	17,456	√	√	√					√	
		Disp. St Yves	Anse à Veau	10,173	√	√	√						

Nord	**Acul**			**52,494**									
		CS la Nativité	Acul du Nord	10,499	√	√	√					√	
		Disp.Camp Louise	Acul du Nord	6,824	√	√	√						√
		Disp.Grison Garde	Acul du Nord	7,349	√	√	√						
		Disp.La Bruyère	Acul du Nord	10,499	√	√	√						
		Disp.de Pillatre	Acul du Nord	10,499	√	√	√						
		Disp. Tovar	Acul du Nord	6,824	√	√	√					√	
	Dondon	CS Dondon		**30,787**	√	√	√					√	
	St Raphaël	CS St Raphaël		**47,825**	√	√	√					√	
	Borgne			***62,835***									
		CAL de Borgne	Borgne	*15,709*	√	√	√					√	
		Disp.Ptit Bourg Borgne	Borgne	*47,126*	√	√	√						

N'Est	**Mombin Crochu**		**33,695**										
		CS Mombin Crochu	Mombin Crochu	13,886	√	√	√					√	
		Disp.Bois de Laurence	Mombin Crochu	19,809	√	√	√						√
	Ste Suzanne		**27,291**										
		Disp.de Ste Suzanne	Sainte Suzanne	13,646	√	√	√						√
		Disp.de Dupity	Sainte Suzanne	13,646	√	√	√					√	
	Disp des Perches	Disp des Perches	Perches	**11,064**	√	√	√						√
	Cs de Carice	CS de Carice	Carice	**13,141**	√	√	√						√
	Vallières		**22,849**										
		Disp.de Vallières	Vallières	9,825	√	√	√					√	
		Disp.de Grosse Roche	Vallières	13,024	√	√	√						√
N'Ouest	**La Tortue**		**34,361**										
		Ntre Dame des Palmistes	La Tortue	19,088	√	√	√	√			√	√	
		CS Marie Curie	La Tortue	3,339	√	√	√						
		Disp.Aux Plaines	La Tortue	2,194	√	√	√						
		Disp. de La Vallée	La Tortue	3,626	√	√	√						
		Disp.de Mare Rouge	La Tortue	2,795	√	√	√						√
		Disp.de Méyance	La Tortue	3,319	√	√	√						
	Baie de Heine		**24,096**										
		CS Baie de Henne	Baie de Henne	2,807	√	√	√					√	

		Disp.Citerne Remy	Baie de Henne	2,415	√	√	√							
		Disp.de Dupré	Baie de Henne	6,261	√	√	√							
		Disp.de La Source	Baie de Henne	6,343	√	√	-							
		Disp.de Petite Rivière	Baie de Henne	6,269	√	√	√						√	
	Anse A Foleur			**26,587**										
		CS Anse à Foleur	Anse-à-Foleur	13,577	√	√	√						√	
		Disp.de Côtes de Fer	Anse-à-Foleur	5,423	√	√	√							
		Disp. de Dity	Anse-à-Foleur	7,588	√	√	√							
Ouest	**Belles Fontaines**	Belles Fontaines *(Act. Comm.)	Croix des Bouquets	**44,945**	√	√	√							
	Cornillon			**66,113**										
		CS Cornillon	Cornillon	66,113	√	√	√						√	
		CS St Vincent de Paul	Cornillon	0										
		CS St Pierre	Cornillon	0										
	Bel Air	CS de Bel Air	Port-au-Prince	**73,328**	√	√	√							√
	St Martin	CS de ST Martin	Delmas	**73,328**	√	√	√							√
	***Trou d'Eau/Crochu**	Trou d'Eau/Crochu *(Act. Comm.)		**36,665**	√	√	√							
	Tayfer	Disp.Tayfer	Carrefour	**36,665**	√	√	√							√
Sud	**Les Anglais**	CAL de Les Anglais	Les Anglais	**30,283**	√	√	√	√			√	√		
	Ile A Vache	CAL de Ile A Vache	Ile-à-Vache	**12,070**	√	√	√	√	√		√	√		

			68,138										
		CS de Bainet	Bainet 22,440	√	√	√					√		
		Disp. de saurel	Bainet 8,476	√	√	√							
		Disp. de Bahot	Bainet 9,598	√	√	√							
Sud'Est	**Bainet**	Disp.de Chomeille	Bainet 5,944	√	√	√							
		Disp.Brézilienne	Bainet 8,749	√	√	√							
		Disp.Bras de gauche	Bainet 5,161	√	√	√							
		Disp. Oranger	Bainet 7,769	√	√	√							
Total ZC	**33 zones ciblées**	**79 sites**	**1,453,075**										
ONG+ZC		**160 sites ou PPS**	**4,460,896**	**164**	**159**	**158**	**38**	**25**	**8**	**31**	**58**	**12**	